

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9898 63-037333  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED OCT 10 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b		c. CITY OR TOWN Overland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 9011 Forest		If outside, give location		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle A Last AUDRAIN			4. DATE OF DEATH Month OCT. 4, 1963 Day Year			5. SEX Female			6. COLOR OR RACE White		
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH 3-31-1873			9. AGE (last birthday) 90			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10a. USUAL OCCUPATION			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country) St. Charles, Mo			12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John Pallardy			13b. MOTHER'S MAIDEN NAME Lucille Primeau			14. NAME OF HUSBAND OR WIFE James Audrain			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Joseph Audrain, 3678 Varweg			18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR FAILURE DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 334 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome assoc. c. cerebral arteriosclerosis PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION 10/4/63			COUNTY STATE		
21. I attended the deceased from 1/21/63 to 10/4/63 and last saw her alive on 10/4/63 Death occurred at 4:25A m on the date stated above, and to the best of my knowledge, from the causes stated.			22a. SIGNATURE Daniel D. Hellman M.D.			22b. ADDRESS 1515 LAFAYETTE AVE			22c. DATE SIGNED 10/4/63		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-7-63			23c. NAME OF CEMETERY OR CREMATORY St. Charles Borromeo			23d. LOCATION (City, town, or county) (State) St. Charles, Mo		
24. FUNERAL DIRECTOR Dallmeyer Funeral Home, St. Charles, Mo.			25. DATE RECD. BY LOCAL REG. OCT 4 1963			26. REGISTRAR'S SIGNATURE R. D. Smith M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300  
Rev. 4/59

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75

HELLMAN  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Eleanor P. Pennington*

Licensed Embalmer No.

*42,83*

P. O. Address

*St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.